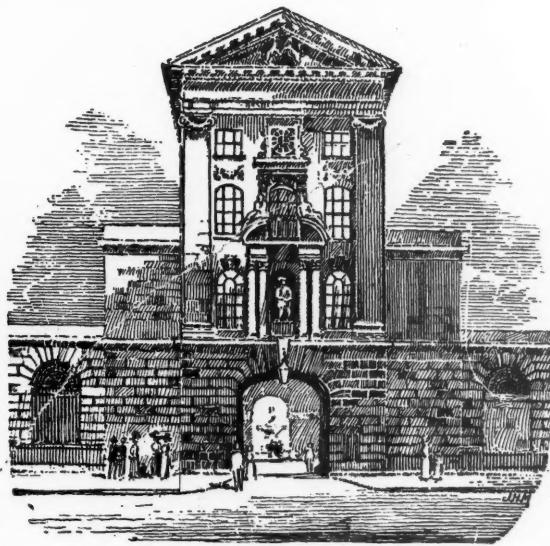


JAN 16 1926

Medical Ltd

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXIII.—No. 4.

JANUARY, 1926.

[PRICE NINEPENCE.

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# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."

— *Horace*, Book ii, Ode iii.

## JOURNAL.

VOL. XXXIII.—No. 4.]

JANUARY 1ST, 1926.

PRICE NINEPENCE.

### CALENDAR.

Fri.,	Jan.	1.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Sat.,	"	2.—Rugby Match v. Harlequins. Home. Association Match v. Old Cholmelians. Home.
Tues.,	"	5.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Wed.,	"	6.—Christmas Entertainment by the Amateur Dramatic Society at 8 p.m.
Thurs.,	"	7.—8.—
Fri.,	"	8.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Fri.,	"	9.—Rugby Match v. Plymouth Albion. Home. Association Match v. Old Carthusians. Away. Hockey Club v. St. Albans. Away.
Sat.,	"	11.—Rugby Match v. Bristol. Home.
Mon.,	"	12.—Dr. Langdon-Brown and Sir C. Gordon-Watson on duty.
Tues.,	"	15.—Prof. Fraser and Prof. Gask on duty. 16.—Rugby Match v. Northampton. Home. Association Match v. Old Mercers. Home. Hockey Match v. Wayfarers. Away.
Tues.,	"	19.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Thurs.,	"	21.—Mid-Sessional Address to the Abernethian Society. Prof. Leonard Hill: "Ultra-Violet Radiotherapy."
Fri.,	"	22.—Last day for receiving matter for February issue of the Journal. Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Sat.,	"	23.—Rugby Match v. Bradford. Home. Association Match v. Aegean F.C. Home. Hockey Match v. Shoeburyness. Away.
Tues.,	"	26.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Wed.,	"	27.—Rugby Match v. Nuneaton. Home.
Fri.,	"	29.—Dr. Langdon-Brown and Sir C. Gordon-Watson on duty.
Sat.,	"	30.—Rugby Match v. R.N.C. Away. Association Match v. Old Bancroftians. Away. Hockey Match v. R.N.C. Home.

### EDITORIAL.

**B**E have discovered what we hope to be a fresh and cheering fact about this new year. We shall find it much easier to convert the 5 (which we undoubtedly shall write in the date for the next six weeks) into a 6 than we found changing 4 into 5 last year.

With this added crumb of comfort we wish our readers "A Happy and Prosperous New Year."

At last the individual headphones for the Hospital wireless have been fitted and vibrate nightly to the joy of the patients. An inaugural ceremony took place in Pitcairn Ward on Tuesday, December 22nd.

The *Daily News* Wireless Fund was represented by Capt. Eckersley, and the installation was officially received by Lord Stanmore and Sir Holburt Waring.

"Listening in" is proving a great success.

\* \* \*

### WAR MEMORIAL.

The Committee dealing with the St. Bartholomew's Hospital War Memorial is very glad to be able to report that a decision has been arrived at as to the general scheme of the Memorial.

In the archway between the Steward's and the Renter's offices are four panels, on which it is proposed to engrave the names of those men who lost their lives in the Great War. Until quite recently these panels were covered with plaster, as also was the domed roof. The plaster has been taken away, and it is intended to fill in the whole of the spaces, including the panels and the arched roof, with Portland stone, and thus to convert the whole into a Memorial. This scheme almost comes within the scope of the funds which have been collected. If there are any old Bart.'s men who are still desirous of subscribing, will they please send their subscriptions to Mr. W. Girling Ball, 77, Wimpole Street, London, W. 1? The Committee is taking this opportunity of informing subscribers of its intentions.

\* \* \*

Many Bart.'s men who are not subscribers will receive this copy of the JOURNAL. May we take this opportunity of urging them to forge this link of connection with your old Hospital?

The Warden of the College has asked us to insert the following notice :

**House Appointments for May, 1926.**

Applications for these appointments will be received after January 23rd, 1926, on which day the notices of vacancy will be posted.

The list will close on February 20th, 1926.

The attention of prospective candidates is called to the two Regulations relating to House appointments printed below :

*Candidates for the post of House Physician should have held appointments as Clinical Clerks in the wards of the Medical Professorial Unit for at least three months, except in special circumstances.*

*Candidates for the post of House Surgeon are required to have been Surgical Dressers to In-patients for at least six months at the Hospital, one period of three months of which should have been spent in the Wards of the Surgical Professorial Unit, except in special circumstances.*

\* \* \*

The apostolic succession to the Cabot Clinic is being carried on this year by Mr. A. C. Visick, who has already left to take up the post of an instructor of surgery in the University Hospital, Ann Arbor, Michigan.

After a very successful year in this clinic Mr. R. S. Corbett is returning to Bart.'s.

\* \* \*

In writing of the Christmas ward entertainments one hardly knows where to start and where to leave off. From the first appearance of the posters down to the final supper parties was a long procession of joyous hilarity. Each year the posters have become a more glowing feature, and this time a private exhibition seems almost merited. The delicacy of the "Hors D'erves," the sparkle of the "Bawling Girls" and the wit of the "High Brow Presentation," this last hailing from Elizabeth, all deserved a longer life than their brief sojourn on the corridor walls.

To comment on each show would be uncalled for, and impossible, as exigencies of existing circumstances made it impossible to pass personal criticism on more than a small number. We hear reported that the "Watchers of the Dawn" was a spectacle not to be missed, and if their performance approached the brilliancy of their attire we are prepared to believe the report. At least one member of the Surgical Staff was reduced to tears by the "Bawling Girls" and their "'Ecclig Adam" (and incidentally it is rumoured that another visiting surgeon succumbed to the mistletoe tradition). The "Endocrines" with devastating "Devil-may-care"

permanently deranged many a parasympathetic system, and the "Sun Babies" from the Resident Staff with their now not to be evaded "bingling" song have, in the words of their producer, "shaken the Nurses' Home to its foundations."

Sister Theatres, Miss Gray and their tailoring team are again to be thanked and heartily congratulated on their work in producing costumes.

The Surgery Party on Boxing Day was a dream of delight to about two hundred and fifty children. The demands made upon the vocal efforts of Father Christmas almost defeated even the lusty larynx of Mr. Row. The party was a roaring success.

Two junior members of the Staff had the novel experience of spending Christmas as patients in the Hospital. We express our deep sympathies to Mr. Harold Anderson and Mr. FitzGerald, whose celebrations were confined almost entirely within the narrow limits of Etherington-Smith Ward. We are delighted to know that both are well on the road to recovery and we wish them a speedy convalescence.

To any who are feeling *blasé* about Christmas, let us recommend to them that they spend the festival at Bart.'s next year, in a ward with a fair sprinkling of children, a charming sister (and which of them is not?) and a typical gang of clerks. Christmas will then have a new meaning for them.

\* \* \*

And here we make our bow.

**FATE OF A COLLEAGUE.**

[Only note on a front sheet.]

Doctor called in. Vomited. Became delirious. B.O. daily—no diarrhoea. Sent up to Bart.'s and admitted.

The H.S. Throats had just removed two beads and five inches of string from the meatus of a small girl.

H.S. (to small girl): Whatever made you push these things in your ear, Polly?

Little Girl: (Silence).

H.S. (to small girl's sister): Do you know why she did it?

Sister: No, Doctor—unless it was 'cos of what teacher said.

H.S.: What did teacher say?

Sister: She said as anything as went in at one of her ears come out of the other.

[Collapse of H.S.]

## HUMOUR AND THE CONSULTANT:

### II. THE PATIENT.

 N one sense the patient is immune from comedy ; he is ill, and is therefore a subject for pity rather than mirth. He demands our sympathy inasmuch as he is diseased and inasmuch as he places himself in our hands, believing that we can and will help him. From this aspect, therefore, he is not fair game for the comic spirit. It is only when we view him as one of ourselves and when he displays certain droll features as an individual rather than as a sick person that he provides any legitimate material for humour. But it is not seldom that we are faced with the patient as a cause of exciting the sense of the ridiculous in us in one or both of these aspects ; it happens rather frequently. And we may express a reasonable hope that even when the individual appeals to our sense of humour this does not make us any the worse doctors.

It has been remarked that patients are nowadays prone to consult a doctor for one of two things : Either to teach him medicine, or to ask him to lead their lives for them. This is, of course, too sweeping a statement, yet these two classes of patients certainly do exist, and in considerable numbers. Though they try the temper not a little, they also contribute some humour to the consultant's life. The knowledgeable patient is so sure of his facts and gets so much satisfaction out of them that it seems almost a pity to disabuse him. Looked at from his standpoint medicine is exceedingly simple : it is somewhat surprising that he consults a doctor at all. For example, blood-pressure is "a man's age with a *i* put in front of it." (It occasionally transpires that a doctor is guilty of the same bit of simplicity, and in any case I suppose a doctor was originally responsible for the fairy story.) No embarrassment arises, however, except when the patient, getting no confirmation of his observation, adds "That's so, isn't it doctor ?" His manner during the earlier part of the consultation generally decides me in my reply. If he has been a pleasant person I say something which comes (or so I suppose) within the category of what is known as "airy persiflage." If, on the other hand, this is one more effort to demonstrate that, after all, medicine is quite easy, only we doctors make it mysterious, I do not hesitate to ask : "Do you mean the systolic or the diastolic pressure ?" That gives the patient an opportunity of retiring gracefully, and neither party is hurt. Sometimes, however, the patient looks unmistakably as though the question is really only a silly quibble ;

and rarely he ventures to tell us so. He is of that type to whom it seems of the nature of a personal affront to suggest that there is any special knowledge or skill in a branch of science or of art which he himself does not chance to have studied. (I have noticed that these patients are generally politicians or schoolmasters or are prominent in the newspaper world.) Should the method of examination be one requiring large experience in order to assess results, he will occasionally be so piqued that he is bluntly sceptical as to the whole business. "You don't *really* hear anything different there, I suppose ?" said one of these funny people to me, quite seriously, when I chanced to mark the outer limit of his area of cardiac dullness with a pencil. He honestly thought I was "dressing the window."

If the knowledgeable patient becomes tiresome there is only one logical way of dealing with him, and that way has already been indicated in connection with the blood-pressure business. I was once being subjected to a lengthy cross-examination, by a large-sized lawyer with a considerable show of knowledge, concerning his boy whom I had just seen, and who was suffering severely from scarlet fever. Pleurisy was present, and this fact had led to the consultation. In the course of my remarks and in support of a fairly good prognosis I advanced the statement that there was no pneumonia. "How do you know there is no pneumonia ?" asked the father. "Because there are no signs of it on examination of the chest," I replied. "And what would the signs be ?" "Diminished resonance, bronchial breathing and fine crepitation." "Oh ! but those are technicalities." "So is the decision a technicality whether or no pneumonia be present." At which the lawyer withdrew to the simple but impregnable attitude of an anxious parent. After the boy's recovery I met the father again ; he referred laughingly to the incident and we became good friends.

The hypochondriac is apt to be very knowledgeable ; he picks up pseudo-medical statements with great avidity, and though he is impatient of the illnesses of his friends, and intolerant of the recital of their sufferings, he adds considerably to the already well-stocked hotchpot of his own medical knowledge by throwing into it other tit-bits which he has learned from them. Still further additions are unfortunately contributed as the result of visits to experts, who are taken off their guard and make use of expressions which, whilst sounding full of positive significance, have, in reality, only a negative value. I was recently consulted by a highly nervous man whose doctor begged me to reassure him (if I agreed) that there was nothing organically wrong with his heart. It appears that he was on the point of reassurance a week before his visit to me, but a friend

urged him to go to a certain cardiologist for still one more opinion, and the expert said he was suffering from "vascular atonia." Back he went into a slough of apprehension and terror, and it was with great difficulty that I convinced him that this diagnosis was tantamount to his own doctor's view of his case.

I suppose most of us extract a certain amount of comedy out of the hypochondriac. I said in my opening remarks that the patient was scarcely fair game in the matter of providing material for laughter. But in the case of a good many hypochondriacs there is this redeeming feature—that they take themselves so seriously, it becomes a duty on the part of the physician, and part of the patient's appropriate treatment, to point this out to them. They have lost their sense of proportion and are therefore ridiculous. For is not a lack of proportion the very essence of comedy? To succeed in demonstrating this to the patient, but without offence, is to put him on the high road to recovery. But it behoves us to walk warily and to watch for our opportunity. We cannot help him to regain his confidence in himself if we sacrifice the confidence he has in us. The risk lies in the possibility that if the doctor does not take him as seriously as he takes himself he will consider that his case is not understood, in which event an attempt at breaking up a concept of ill-health by too robust and good-humoured an attitude will fail. As I say, we must watch for the appropriate chance.

A barrister of some eminence was one day reading out to me a list of symptoms, which became more and more trivial as he proceeded. He concluded each statement by a request for an authoritative pronouncement as to his proper conduct in respect of each situation involved, as is the frequent wont of such patients. I managed to satisfy him fairly well, and so to preserve my sense of gravity that the answers should appear to carry weight as being the outcome of careful deliberation and mature experience. The gist of each reply was neatly pencilled in the blank space left for it. When we arrived at about No. 9 on the list—a more meticulous and finicking question than any that I had hitherto answered—I began to doubt if I was really helping the patient the best way. Whilst I was hesitating I caught sight of a penny lying on the floor by the side of the couch upon which the man had lain during my examination of him. I picked it up and handed it to him. "This is your penny, I believe?" I said. "No, it is not mine," he replied. "Are you quite sure?" I asked. "Quite," answered the patient. Looking a little troubled I said, "That's rather a nuisance." "Why?" said the patient, beginning to exhibit a show of testiness at this interruption of his questions by an incident of such obvious irrelevancy.

"Because if it were yours," I said, "you might take it and the affair would be at an end. As it isn't yours I don't know what to do with it. If I send it to the patient who was here immediately before you it will cost me three-halfpence in postage, and there is the chance that it doesn't belong to him. If I put it in the missionary box—well, as it is not my property I have no right to do that . . . ." By this time the patient was thoroughly roused; the interruption was unpardonable, the occasion absurdly insignificant. "What the devil does it matter *what* you do with it?" he burst out in a pet. "You are quite right," I said, "it doesn't matter an atom. Neither does it matter what answer I give to that last question of yours," pointing to the paper which he held in his hand. I had taken the risk. There was a moment of doubt during which the issue hung in the balance; then the man's face changed, it lost its look of deep concern and a smile stole slowly but reassuringly across it. I knew that the medicine was a good medicine and that it had been administered at the right moment.

X.

(*To be concluded.*)

## SOME NOTES ON THE SURGICAL ANATOMY OF THE TONGUE.



THE tongue is composed chiefly of a mass of muscles covered by a mucous membrane. The latter is very firmly fixed to the muscular mass which it covers.

The tongue may be divided into two main parts for description:

- (a) Anterior two-thirds—the buccal portion.
- (b) Posterior one-third—the pharyngeal portion.

Squamous epithelium covers the tongue, and on the surface of the organ several varieties of papillæ are found:

- (1) Filiform—the most numerous.
- (2) Fungiform.
- (3) Circumvallate—the largest papillæ.
- (4) Foliate.

The filiform papillæ, as their name implies, are fine hair-like processes, usually quite short and massed closely together on the buccal portion of the tongue.

The fungiform papillæ are a little larger, less numerous, and dotted about amongst the former variety and generally show as multiple red points.

The circumvallate papillæ vary in number from eight to twelve, and are arranged in a V-formation. They are situated at the junction between the buccal and pharyngeal portions of the tongue, the apex of the V

being in the middle line, and the arms coming forwards and outwards to the margins of the tongue. Most of the taste-buds are situated in the sides of these papillæ, which normally stand up a little above the surface of the tongue, and are each surrounded by a little ditch.

The foliate papillæ are few in number and are situated far back on the sides of the tongue. They are unimportant, apart from their association with lingual neuralgia. In this condition the patient has a severe pain in the tongue, which is often associated with a prominence of one of the foliate papillæ, the patient, and sometimes his doctor, diagnosing cancer.

The pharyngeal portion of the tongue is devoid of papillæ; it is covered by lymphoid tissue—the lingual tonsil. This is sometimes seen to be greatly increased in amount, especially in such conditions as *status lymphaticus*.

**Muscles.**—The muscles of the tongue are divided into extrinsic and intrinsic. The latter form the main mass of the tongue, and cause it to alter its shape and to become pointed on protrusion. The extrinsic muscles join the tongue to surrounding bony points and so control its movements. The names of these muscles are sufficient to explain their attachments, viz. styloglossus, hyoglossus, palatoglossus and genioglossus; the last of these is somewhat fan-shaped in form, and it is the posterior fibres of this muscle which are largely responsible for protrusion of the tongue. We see, therefore, that when the nerve supply to one side of the tongue is cut off the muscles do not protrude the tongue on that side, and so it points towards the paralysed side when it is "put out."

**Nerve supply.**—The motor nerve to all the muscles of the tongue except the palatoglossus is the hypoglossal nerve. The nerve of ordinary sensation to the anterior two-thirds is the lingual nerve, and the nerve connected with the sense of taste is the chorda tympani; the glossopharyngeal is the sensory nerve to the posterior third of the tongue.

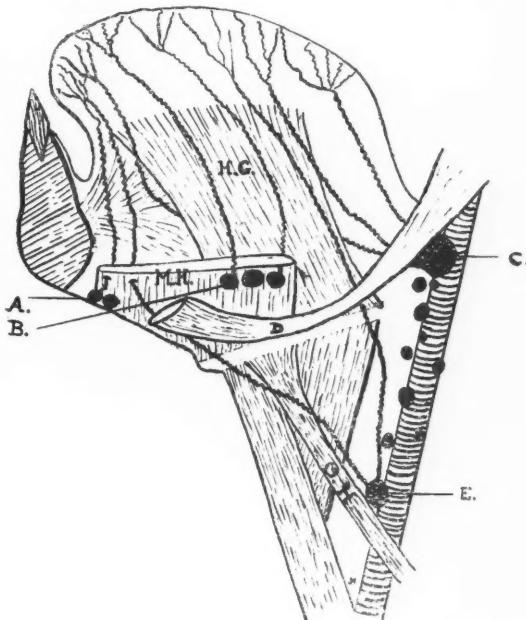
**Vascular supply.**—The main arterial supply to the tongue is *via* the lingual arteries, one on each side, branches of the external carotid arteries. The lingual artery in its last part is known as the ranine artery, and is merely covered by mucous membrane. As a preliminary step to hemiglossectomy, or in cases of inoperable carcinoma of the tongue to diminish the rate of growth, the lingual artery is often ligatured. The artery may be tied in its first part, but on account of the dense venous plexus here and the limited space, ligation is more often carried out in the second part of the artery, where it is lying deep to the hyoglossus muscle; it must be remembered, however, that when tied in this situation the dorsalis linguae branch is not "cut off."

As well as *venae comites* with the lingual artery, there is a ranine vein, which runs superficial to the hyoglossus muscle; all drain into the internal jugular vein.

**Lymphatics.**—The lymphatic vessels of the tongue may be divided into four groups:

- (a) Apical.
- (b) Marginal.
- (c) Central.
- (d) Posterior or basal.

The lymphatic vessels of the apical group drain to the submental lymphatic glands, and also to a gland situated immediately above a point in the neck where the omohyoid muscle crosses the internal jugular vein at



LYMPHATIC DRAINAGE OF TONGUE.—A. SUBMENTAL LYMPH-GLANDS. B. SUBMAXILLARY LYMPH-GLANDS. C. JUGULO-DIGASTRIC LYMPH-GLAND. D. DIGASTRIC MUSCLE. E. JUGULO-OMOHYOID LYMPH-GLAND. H.G. HYO-GLOSSUS MUSCLE. OH. OMO-HYOID MUSCLE. M.H. MYLO-HYOID MUSCLE.

the level of the cricoid cartilage. It is to be remembered that one apical lymphatic vessel crosses the middle line to terminate in the submental gland of the opposite side.

The marginal vessels drain into the submaxillary lymphatic glands, and also into the internal jugular chain of deep cervical glands; most important, however, is a large gland situated over the internal jugular vein immediately below the point where the posterior belly of the digastric muscle crosses the internal jugular vein; it is known as the jugulo-digastric or principal lymphatic gland (Hauptganglion of Küttner).

The vessels of the central group drain the central part of the tongue and pass downwards in the mid-line between the muscles of the tongue, and end on either side in the principal gland and other deep cervical glands, even down to the omohyoid gland already mentioned.

The posterior group of lymphatic vessels drain the posterior third of the tongue, beginning as a network around the circumvallate papillæ and spreading backwards, eventually to drain chiefly into the principal gland of Küttner. The vessels in this group from the two sides join together in the centre, so that the lymph from a lesion on one side of the tongue in this area may drain to the glands of the opposite side.

We see therefore that during an operation in the neck for removal of glands for carcinoma of the tongue, all the glands along the carotid sheath from the posterior belly of the digastric muscle to the omohyoid muscle (*glandulæ concatenatæ*) must be removed; the submaxillary lymphatic glands must also be excised (this usually requires removal of the submaxillary salivary gland as well); and if the carcinoma is near the apex of the tongue the submental lymphatic glands on both sides must be removed.

Some surgeons recommend that the glands along the carotid sheath right up to the base of the skull ought to be removed; but this step is a very drastic addition to the operation.

It should be remembered that the lymphatic vessels of the apical, central and posterior groups may all drain to the lymphatic glands on the opposite side to the lesion in the tongue.

*Foramen cæcum*.—Lying behind the apex of the V formed by the circumvallate papillæ is the foramen cæcum. This, when present, is the remains of the upper end of the thyro-glossal tract; it rarely, if ever, exceeds 1 cm. in depth. It is an interesting fact that the foramen cæcum seems not to be found in other mammals and is peculiar to man. Occasionally a cyst or a solid swelling composed of thyroid tissue is found at the site of the foramen cæcum. It may lead to mistakes in diagnosis, and has been known to lead to the condition of myxædema or cachexia strumipriva, since it invites removal, but yet may be the only thyroid tissue the patient possesses.

As a developmental abnormality there may be noted bifid tongue. Amongst the animal kingdom there are certain mammals, birds and reptiles which normally have a tongue which is divided into two anteriorly, and very rarely this is found in man. It is usually not inconvenient, but for cosmetic reasons the adjacent edges may be pared and sutured.

Before leaving the tongue mention should be made of

two conditions which are not infrequently met with in the floor of the mouth. The first is that of a bluish, definitely cystic swelling lying to one side of the mid-line in the angle of junction between the mobile part of the tongue and the floor of the mouth, and known as ranula. The pathological anatomy of this cyst is somewhat confused, and it is frequently said to be derived from the glands of Blandin and Nunn. Now this seems very improbable, as these glands are situated on the under-surface of the tongue quite near its apex—a position well away from the common ranula. A cystic swelling in the site of these glands is very occasionally met with and is quite unlike the common ranula in position. A ranula more probably arises in connection with the sublingual salivary gland or its duct.

The second lesion in the floor of the mouth which is not uncommonly seen is the sublingual dermoid. It is typically a round, yellowish, cystic swelling in the middle line of the floor of the mouth, which can be felt both beneath the chin and in the floor of the mouth internally, as it is situated between the two genioglossus muscles. It is often said that this is derived from the thyroglossal tract as a dilatation of an unobiterated portion of it; but since it is out of the direct line of the thyroglossal tract as it passes from the foramen cæcum to the hyoid bone it seems improbable that this should be so. Stronger evidence still is that the thyroglossal tract is lined, whenever it is patent, by a variety of ciliated columnar epithelium, whereas these sublingual dermoids are lined by a stratified squamous epithelium.

JOHN P. HOSFORD.

## PHARYNGEAL DIVERTICULA.



THE following cases are reported with a view to discussing the two common methods of treatment of this condition. In each case the diverticulum was a large one and arose from the posterior pharyngeal wall opposite the cricoid cartilage, presumably between the upper oblique and the lower circular fibres of the inferior constrictor of the pharynx, as diverticula in this region most commonly do.

**CASE 1.**—A male, æt. 42, was admitted to hospital on June 18th, 1923.

Two and a half years ago he began to suffer from dysphagia. At first this was most marked when he swallowed liquids, which, he said he always vomited. When solid food was taken some passed into the stomach and some was vomited after a variable period. There was no nausea, but a choking sensation was experienced before vomiting. The vomit consisted of clean food and mucus. There was a gurgling sound in the throat on swallowing. He stated that he had not lost any weight.

*Condition on examination*.—The patient was a thin, pale man. No abnormality was found in connection with the mouth or upper part

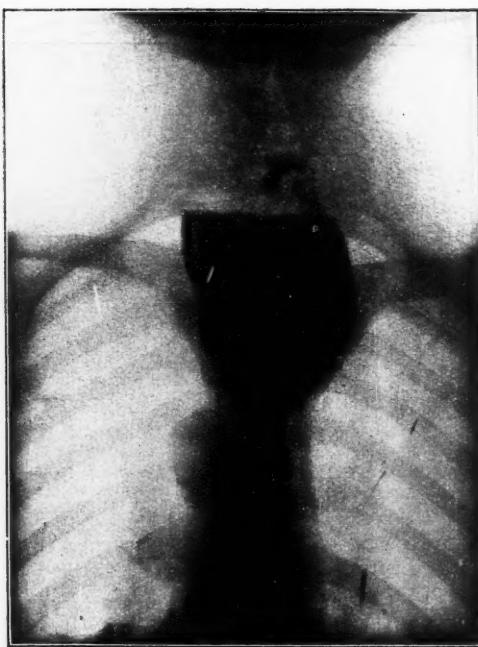


FIG. 1.



FIG. 2.

of the pharynx. When he swallowed fluid a swelling appeared in the lower half of the neck, more marked to the left of the midline than to the right.

An X-ray photo, taken after a barium meal, showed a pharyngeal diverticulum (Fig. 1).

*Operation.*—Under local anaesthesia the pouch was exposed through an incision along the anterior border of the left sternomastoid, and freed from adhesions. The fundus of the pouch was drawn upwards and fixed in the skin incision. The site of the pouch was packed with gauze, which was removed on the following day.

Six weeks after the operation the wound was reopened. The pouch was completely removed and the opening into the oesophagus sutured. The patient was fed by the rectum for three days after the operation. There was a small amount of discharge from the wound in the neck.

The patient made a complete recovery after the operation and has been able to swallow any kind of food ever since. One year later an X-ray photo was taken. This showed that there was no sign of any



FIG. 3.

diverticulum. Two and a half years after the operation the patient was again seen and stated that he was swallowing food without any difficulty. An X-ray was taken, and this showed a recurrence of the diverticulum (Fig. 2).

**CASE 2.**—A female, at 63, was admitted to hospital on June 23rd, 1925. Three years ago she began to have a gurgling sensation in her throat on swallowing fluids. Two years ago she began to suffer from dysphagia, at first most marked for fluids; this has gradually got worse until the time of admission to hospital. After taking two or three mouthfuls of fluid she regurgitates it, together with some particles of undigested solid food taken some time previously. Solids taken alone cause less trouble than fluids. Six months ago the patient noticed a swelling in her neck on attempting to swallow. Pressure over this, she said, caused regurgitation of fluids into the mouth. There has been marked loss of weight.

*Condition on examination.*—The patient was a thin, healthy-looking woman. On attempting to swallow fluids a swelling appeared on both sides of the lower half of the neck, more marked on the left than on the right side. An X-ray photo showed a pharyngeal diverticulum (Fig. 3).

*Operation.*—Under general anaesthesia (endotracheal), the pouch was exposed by an incision along the anterior border of the left

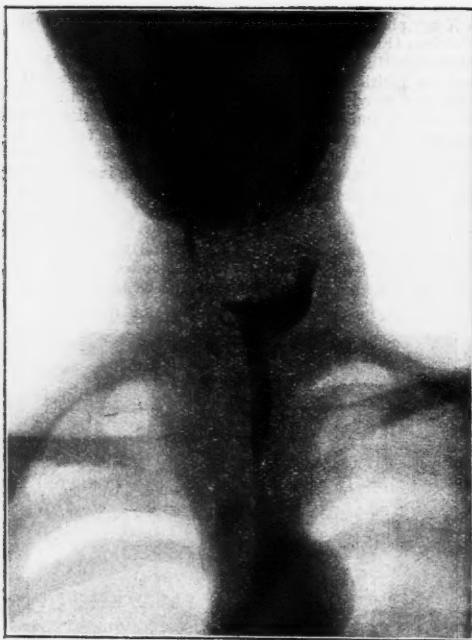


FIG. 4.



FIG. 6.



FIG. 5.



FIG. 7.

sterno-mastoid, and easily separated from surrounding structures. The pouch was twisted and drawn upwards, so that the fundus could be sutured to the deep aspect of the sterno-mastoid in the region of the angle of the jaw. The skin incision was completely closed.

On the day after the operation the patient was able to swallow fluids without any difficulty. An X-ray photo, taken twelve days later (Fig. 4), showed that the pouch had not been completely obliterated. Three months after the operation the patient was again seen. She said that she was able to swallow any kind of food without difficulty. Another X-ray photo was taken and this showed the pouch to be increasing in size (Fig. 5).

**CASE 3.**—A male, at. 65, was admitted to hospital on September 24th, 1925. Six months ago the patient noticed that he was beginning to have difficulty in swallowing his food, more especially solids. This condition gradually became worse until three months ago, when he began to regurgitate unaltered food after every meal. Six weeks ago he noticed a swelling in his neck while taking food. During the last six months he has lost three stone in weight.

**Condition on examination.**—The patient was a thin, pale man. When swallowing fluids a swelling appeared on both sides of the lower part of the neck, deep to the sterno-mastoid muscle. On pressure being made over this, fluid could be made to regurgitate into the mouth. An X-ray photo showed a pharyngeal diverticulum (Fig. 6).

**Operation.**—Under general anaesthesia (endotracheal) the pouch was exposed as in the previous operations. Owing to the large size of the pouch it was decided that an ordinary diverticulopexy, as in Case 2, would leave too large a swelling under the scar. So the pouch was twisted and suspended to the sterno-mastoid behind the angle of the jaw, but the fundus of the pouch was brought out of the wound, which was then sutured closely around it.

Eleven days later the fundus of the pouch was removed under local anaesthesia, the stump being sutured with a purse-string suture. The skin was then sutured over the stump. The patient made a complete recovery from the operation and was able to swallow any form of food. An X-ray photo taken on the day after the second operation showed that there was still a small portion of the diverticulum remaining.

The treatment in Case 3 was, in essentials, the same as that in Case 2, the operation of diverticulopexy being slightly modified owing to the large size of the pouch. In both these cases the results must be considered only as a partial success, although the patients were completely freed from symptoms; for as long as that part of the diverticulum which is adjacent to the pharynx remains unobliterated, the pouch will continue to increase in size. There is undoubtedly evidence that this is occurring in Case 2. In these cases the pouches should be removed completely only if symptoms recur, for, owing to the ages of these patients, it is possible that the symptoms will not return.

In cases where the pouch has been completely removed recurrences are unusual, but such cases have been reported previously.

One of the suggested reasons for the formation of these diverticula is that there is a temporary failure of relaxation of the lower circular fibres of the inferior constrictor of the pharynx at the moment when food is passing from the pharynx to the oesophagus. If these diverticula are discovered in an early stage, they can be prevented from increasing in size by the passage of oesophageal bougies. When the pouch has been completely removed, it is advisable that a bougie should be passed once a week for six to twelve months to prevent a recurrence of the condition.

The operation of diverticulopexy has certain advantages over an excision of the sac in two stages. As a general rule it is a simpler and safer operation. The patient is not subjected to a second anaesthetic, and he can be fed by the mouth as soon as he is round from the anaesthetic, whereas if an excision is performed rectal feeding is advisable for several days.

After considering these cases it seems that the best form of treatment is to perform a diverticulopexy. A few days after the operation an X-ray photo should be taken. If the pouch has been completely obliterated no further operative treatment is necessary. If any of the pouch is still remaining a week or ten days after the first operation it should be completely excised and the opening into the oesophagus sutured. Whichever form of treatment is adopted, a bougie should be passed once a week to prevent any recurrence.

I am indebted to Prof. Gask and Mr. Dunhill for permission to publish these cases, and to Miss Vaughan, of the Dunn Laboratory, for the preparation of the X-ray prints.

FRANK A. BEVAN.

## SENSITIZED STREPTOCOCCAL VACCINE AS A ROUTINE PROPHYLACTIC AGAINST PUERPERAL SEPSIS.



HIS article embodies the results of a statistical investigation into the effects produced by the routine use of this vaccine on the cases attended by the Extern Midwifery Department.

The term "puerperal sepsis" has been used above in its generic sense, to indicate all septic conditions of the puerperium, irrespective of their being general or localized.

Such conditions may give rise to marked signs and symptoms, while on the other hand the resultant phenomena may be so slight as to be disregarded and put down to "constipation," "influenza," etc. The arbitrary selection of a border-line between normal and abnormal is clinically unsound, but a standard is essential for statistical purposes.

Thus, in this investigation the following conditions were taken as constituting "morbidity" (*i. e.* puerperal "sepsis"):

- (1) A temperature of 100° F. or over.
- (2) A pulse of 100 or over persisting for more than twelve hours.
- (3) Both 1 and 2.

In this category a percentage of non-septic cases has—of necessity—been included, because the facts on

the case-sheets were not definitive enough to warrant their exclusion. The figures, therefore, tend to over-estimate rather than under-estimate the incidence of septic invasion.

In the period under review doses were given in varying ways. Summarized, these were as follows :

(1) *A single dose* of 250 millions within 24 hours after the birth of the child.

(2) *Two doses* of 250 millions—

(a) In first 24 hours.

(b) In second 24 hours.

(In both of these methods the initial dose was sometimes unfortunately delayed beyond the first 24 hours.)

(3) *Two doses*—

(a) 250 millions in first 24 hours.

(b) 500 millions in second 24 hours.

(4) *Five doses*—

(a) Immediately after labour, 250 millions.

(b) 24 hours after labour, 500 millions.

(c) 48 " " 500 "

(d) 72 " " 1000 "

(e) 96 " " 1000 "

This last method was used in those cases in which manipulations or operative interference were necessary (250/500 + method).

The total number of cases investigated was 556.

The results are given chronologically.

Months.	Vaccine treatment.	Morbidity.
December, 1920	None	13·53 per cent
January, 1920		
December, 1924—		
(First half	None	15 "
(Second half	250/250 method	6·6 "
January, 1925	250 method	6·7 "
February, 1925	250/500 method	6·4 "
March, 1925	250/500 and 250/500 + methods	4 "
April, 1925	As for March	2·5 "

A comparison of the average percentage morbidities for the periods in which vaccine was given with those of the "no vaccine" times shows :

No vaccine given . . . . . 14·26 per cent.

Vaccine given . . . . . 5·24 "

These figures do not indicate the full value of prophylactic doses of the vaccine in labour cases, because they give no evidence of its use in the modification of the results of septic invasion.

A careful comparison of the charts of all the septic

cases showed that when vaccine was given prophylactically the pulse and temperature were always lower than in the "no vaccine" cases, and the duration of the illness was shortened.

This fact is supported by the fall in morbidity in those months in which the 250/500 + method was used on cases where septic invasion was encouraged by manipulations, etc.

Several cases could be quoted to show the value of vaccine in this respect, but the following must serve as one instance :

Patient, æt. 44; multipara; ten children. A large, fat woman with very lax abdominal walls and wide divarication of the recti muscles.

Membranes were unruptured after five hours of moderate labour pains, and the presentation was left occipito-posterior.

Fifteen minutes after the waters broke patient suddenly collapsed. The temperature fell to 97° F. and the pulse became 125.

Patient was admitted to hospital with a provisional diagnosis of rupture of the uterus.

A 9½-lb. baby was delivered—under chloroform—with some difficulty, and the diagnosis was confirmed. The uterus was packed temporarily, and three hours later abdominal hysterectomy was performed.

Vaccine was given immediately after delivery and continued in increasing doses up to 1500 millions. After an initial rise lasting for three days both temperature and pulse fell below the level of morbidity. The woman was discharged quite well after three weeks.

It may be noted that cultures taken from the cervix on the second day resulted in a profuse growth of haemolytic streptococci.

The case illustrates the value of the vaccine in what was an undoubted infection, and is specially noteworthy in that the patient's resistance must have been very low.

The facts and figures quoted above are not sufficient to justify definite conclusions as to the real value of the vaccine, but, in so far as it went, the investigation elicited certain interesting points. Summarized, these were as follows :

(1) That prophylaxis—by any method—is valuable in reducing the incidence of morbidity.

(2) That use of the vaccine in this way modifies the results of septic invasion, should it occur.

(3) That the 250/500 method is best in "normal" labours.

(4) That the 250/500 + method is best in "abnormal" (i.e. operative) labours.

The writer is indebted to Dr. Donaldson for his permission to publish the results of this investigation.

J. P. W. JAMIE.

## UNUSUAL COMPLICATIONS OF URETERIC CALCULUS.

**A**HIS interesting case illustrates the difficulty in diagnosis of the cause of symptoms which may arise from a calculus impacted in the ureter.

The clinical abstract of the case is as follows :

A. H.—, a single woman, at. 50, was admitted to hospital on October 6th, 1925, with frequent vomiting and pains in the epigastrium, head and limbs of three days' duration.

Her past history was very indefinite, but she attended the outpatient department of another hospital for some years with general debility and occasional attacks of vomiting. There was no history of jaundice or of pain suggesting a renal origin.

On admission her temperature was  $103^{\circ}$  F., pulse 120, respirations 26. There were no abnormal physical signs on initial examination apart from slight epigastric tenderness. The same evening she had a rigor and vomited. For the next four days her clinical picture remained unaltered except for distressing flatulence. Micturition was normal and the urine clear.

On the 10th she had frequent and scalding micturition and the possibility of pyelitis was considered, but the urine showed only a very faint trace of albumen. The temperature became hectic, and on the 12th there was definite tenderness in the left post-renal angle and in both hypochondria. A catheter specimen of the urine was loaded with *B. coli*, but contained no pus.

On the 13th she had a second rigor and two more rigors the next day. A blood-count showed a polymorph leucocytosis of 18,000.

The patient's abdomen became very distended and was diffusely tender, especially over the liver; there was also oedema in the right lumbar region. As her general condition was becoming worse, the possibility of either retro-cæcal appendix with early pylephlebitis or right perinephric abscess led to a laparotomy on the 16th.

At operation the abdominal viscera were thoroughly examined. The appendix, liver, gall-bladder and right kidney were normal, but the left kidney felt abnormally fixed and shapeless. There was marked distension of the large bowel, but no mechanical obstruction. An exploring needle failed to find pus above or below the diaphragm.

On the 17th the patient was much weaker. A blood-culture gave a growth of mildly haemolytic *B. coli*.

On the 18th she had a severe rigor, and she died on the 20th.

At post-mortem examination the following interesting condition was discovered :

The left kidney was gangrenous, the upper pole being markedly necrotic. On examining its pedicle the renal vein was found to be filled with suppurating blood-clot. The upper half of the left ureter was slightly distended with purulent fluid, and there was a small calculus impacted just above the brim of the pelvis, which had caused ulceration of the walls of the ureter at this spot. The ureteric veins from above this point up to the renal vein were thrombosed, and the thrombosis also involved the left ovarian vein.

From the post-mortem findings it was clear that an impacted calculus in the left ureter had led to ulceration of its walls and to an upward-spreading thrombosis, which involved the renal vein, causing gangrene of the kidney.

I wish to express my thanks to Mr. E. W. G. Masterman, Medical Superintendent of St. Giles's Hospital, Camberwell, for permission to publish this case.

E. B. BROOKE.

## A MONSTER.

### CONGENITAL AMAUROSIS, WITH ASSOCIATED POLYCYSTIC DISEASE OF BOTH KIDNEYS AND OTHER ABNORMALITIES.

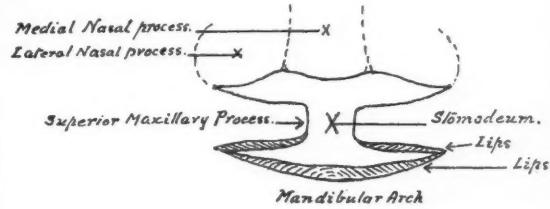
**A**THE subject of congenital abnormalities is one which has received much attention from many writers, usually speculative, and is one which still requires solution.

The patient, a male child, at. 2 days, was admitted to the Evelina Hospital for Children owing to difficulty in feeding. Examination showed that the child was microcephalic, with a complete hardlip and cleft palate. On opening the eyelids a pad of adipose tissue was seen in each orbit and no semblance of an eye.

There were two supernumerary digits on each hand.

The mouth showed complete absence of the premaxilla bone with consequent failure of union of the superior maxillary processes. The cleft was median in position, and on either side projecting medially were two ridges—the palatal processes.

The nasal septum was present as an ill-developed ridge between the two superior turbinated bones.



*Chest* : Left lung no air-entry, whereas right appeared normal.

*Heart* : Sounds normal.

*Abdomen* : Genital and anal orifice normal.

*Back* : No spine bifida.

*Course of case*.—On admission he was given a feed of milk and water by means of a glass pipette and rubber teat; after two minutes he stopped breathing and became cyanosed. By means of artificial respiration and holding the child up by its feet breathing was restored.

Two hours later a  $5\text{j}$  feed was given by pipette with a similar result. On this occasion by auscultating the chest *râles* were heard. It was thought that there was an abnormal communication between oesophagus and trachea.

The next feed was given by means of a stomach-tube, and nothing untoward happened. Four feeds were given successfully in this way. Later the tube was coughed up and every effort to re-introduce it failed.

A small feed was given by pipette, and, as on the previous occasion, artificial respiration was administered. Another feed was given by the same method, and after it all attempts at resuscitation failed. The child died in asphyxia, having lived 96 hours.

### Post-Mortem Examination.

#### Macroscopic observations :

*Eyes*.—In each orbit, embedded in adipose tissue, was found a green, bead-like body attached posteriorly by a stalk, which appeared to be the optic nerve.

*Trachea and oesophagus*.—The epiglottis was abnormally small, and behind the cricoid cartilage the oesophagus was stenosed. The opening allowed of the passage of a No. 5 gum-elastic bougie. Below the stricture the oesophagus appeared normal, also the stomach and intestines, both small and large.

There was no communication between the oesophagus and trachea.

*Lungs*.—There was atelectasis of the left side, with bronchopneumonia of the right lower and middle lobes.

*Heart*.—A patent ductus arteriosus, which was larger than the normal pulmonary artery.

*Kidneys*.—Larger than normal, showing a few small cysts on the surface and with dilated calices.

*Brain*.—Small; optic nerves present.

*Microscopic observations* (reported by Sir Bernard Spilsbury):

*Eye*.—There was a complete eye. The cornea had squamous epithelium attached.

The lens appeared normal; the vitreous humour showed degenerative changes, probably calcareous.

There were several retinal haemorrhages.

The retina was complete.

*Kidneys* showed definite cystic changes present on the surface, glomerular tufts and tubules.

#### Conclusions.

The eye was atrophic—a condition which had undoubtedly commenced *in utero*.

The kidney exhibited congenital polycystic disease.

In recording this case it is interesting to note the many abnormalities found. Congenital polycystic disease has been seen in a case as early as this one. The extraordinary eye condition, which, for some unknown reason, has atrophied before birth.

I venture to draw an inference from these findings, more especially as I have failed to procure any literature on the subject; when patients are seen suffering from congenital defects the condition of all organs should be considered, especially the kidneys.

G. KELSEY LOVEDAY.

### SEA-SERPENTS.

**R**USKIN has a delightful paragraph (so delightful, indeed, that it sent my friend K— into raptures), eulogizing a painting of one of those serpents of the sea which are famed in fable and antique legend to wanton in deepest ocean, far from the haunts of man. I know not if such exist in truth, but we can well imagine the creature, its sinuous tail lashing the scudding waters, scattering now the mud-dwellers five thousand fathoms from the pure air of the Pacific; anon swirling majestically through the spray of one of the lesser oceans.

But let your eyes dwell in joy upon the object of our discourse; such a galaxy of polychromatic scales surely never adorned a product of this debased age. It must be of the offspring of Tellus and one of the first-born of the earth. Behold! It is displayed, I know not to what length, a full hundred feet and more, gloriously bedecked with discs and circles, rings of pure gold, patches of deepest crimson, silver stars, bright bands of emerald—

"A gordian shape of dazzling hue,  
Vermilion-spotted, golden, green, and blue;  
Striped like a zebra, freckled like a pard,  
Eyed like a peacock, and all crimson-barr'd."

It is coiled (as he says) in the most intricate interwindings and the most delicate knots; withal it is as broad as a man's body. Its head is a masterpiece of

glory and venom; a bifurcating tongue projects as though about to lick "a milk-white heifer, lowing at the skies" into the maw from whence it springs; fire (surely the flame and the smoke should be held sacred to the terror of the East, and the enemy of all good knights—the dragon) issues from its nostrils in such a stream that surely no morsel could pass those portals without becoming a burnt offering!

Such is our serpent, and such, in the main, Ruskin's account of it.

We wonder, now, where the painter of this visionary creature should have culled his imaginative entity. (The imagination, O Reader, of the Sons of Art is so powerful as almost to render mythical beings concrete.) Had he, wandering by the sea-shore—it is said that the gods are particularly condescending to mortals of genius—been met by the chariot of Neptune (or of Oceanus, according to his period), and conveyed for a space to the Temple of Watery Delights and the splendour of the palaces of the sea? Had he been shown the denizens of the deep, extinct and living, until his fancy had been caught by this gaudy subject, long since dead, and been allowed to carry away memories of it as an inspiration? Or had he been taken in a dream to Circe's Island or to the Garden of Faud? For surely it was no mortal imagination that conceived this scintillant Ophidian; neither is it an object commonly to be seen sailing the oceanic billows in sweet contentment, warring with no one:

"I fought with none, for none was worth my strife."

Some Spirit of the Ether must have murmured in his ear, have mixed his colours, have directed his eye and brush when he wrought this serpent. It is a thing divine, no less; to be classed with the wonders of Ancient Greece, with the Parthenon and the Sphinx, and the Colossus of Rhodes. For, where they are noble, this excels in beauty; where they are mighty, here is an object of consummate splendour.

But I have yet to remark upon the most curious feature of his phenomenal caricature. This serpent, which skilfully balances itself (as a deified serpent only may do with complete success) on its tail, stands—if such a term be permissible—on dry land! Land-wrecked! We are left to determine for ourselves the origin of this singularity. Some giant convulsion, doubtless, had resulted in the upthrusting of a new continent, leaving this monster stranded. Turn, gentle reader, if you have been constrained to peruse thus far, to the fuller description which I have indicated. Take from your library a certain volume of Ruskin and read the few paragraphs preceding those in which our protean sinuosity is considered. You will perceive that the author

takes exception to the construction of a certain tree by an eminent artist of his day. He declares that there was never any such tree upon the earth; at each branching the combined width of the limbs is less than that of the trunk, whereas they should at least be of equal size. In short, the tree tapers, the which no tree that has a counterpart in life should do.

Therefore, says Ruskin, it is no tree, but is a multi-coloured sea-serpent, with rings and spots, and a forked tongue, and is standing, albeit on dry land, on the coils of its leviathantine tail.

S.

## STUDENTS' UNION.

JOINT meeting of the Abernethian and Debating Societies, held on December 3rd, 1925, Sir Thos. Horder, Bt., in the Chair. The minutes of the previous meeting of the Debating Society were read, approved, and signed.

The PRESIDENT called upon Mr. E. A. Freeman to propose—

"That in the opinion of this House, patients benefit more by the art than by the science of medicine."

Mr. FREEMAN said that the arts were older than the sciences, and that medicine was no more efficient to-day than when it was wholly an art. This was proved by antediluvian longevity. Empiric treatment was often more certain than rational, and natural aptitude produced better work than acquired method. He reminded the House that pus was drained from abscess cavities to-day just as it was in Neolithic times, and that patients 100 years ago were as well digitalized as they were to-day; scientists, after wandering in the arid deserts of digitonin, digitoxin, digitalin, etc., were returning to the fruitful plains of the fresh herb. Some were born with the bedside manner, some acquired it, while others thrust it from them and became pathologists. Science was the tool in the hands of art.

Mr. STANLEY JONES, opposing, endeavoured to narrow the limits of discussion by eliminating from it surgery and nursing. He said science was the search for, and use of, truth and was not confined to the laboratory, and that art was practical skill guided by rules. An artist need not know the principles underlying his rules, but a physician not knowing those underlying the rules of his art would be a menace to the community. The artist cannot meet emergencies, but the scientist knowing his principles can deduce from them his course of action. He quoted insulin, X-rays and endocrine therapy as examples of the efficiency of the science where the art had failed.

Mr. H. D. FRASER stressed the influence of the art on the commoner complaints, and spoke with emotion of neuroses leading to bad temper.

Mr. H. V. DICKS thought that the motion reflected the superficial view-point of the surgeon. Medical science established the laws underlying disease and health, and without them the art would be useless.

Dr. P. HAMILL did not wish to decry the science. "The more of science we have, the better." "Scientia est aurea," which being interpreted is, when we have given the patient all that science can give, he will have nothing left to pay for convalescence." (Laughter.) Scientists, wrapped up in elaborate investigations, might forget essential clinical details. "The sole of the foot is sometimes beneath the notice of the scientist." Old post-mortem reports in the Kinnaird Library were labelled "Completed Cases." "What can it profit patient to become a completed case?"

Prof. FRASER considered that the subtlety of the motion reflected the weakness of the proposer's case. Out-patients, given triangular tickets, representing bottles of medicine, were said to be benefited by the art of medicine. What they really benefited by were the blue eyes of the junior H.P., because the patient believed him to be scientific.

Mr. PICKUP GREENWOOD said that science edentulates in cases of pernicious anaemia, where art can do nothing, but the patient arrives at the P.M. room equally in either case.

Mr. THROWER said that patients came to doctors because they

were in trouble and the relief of that trouble was the essential duty of the physician, wherein his art was of more service than his science.

Mr. MELLOWES, brandishing a fractured pisiform, felt that the scientific application of a cock-up splint had been of less benefit to him than his artistic prescription of  $C_6H_5OH$ , *p.r.n.*

Mr. FREEMAN summed up briefly, and a vote was taken as follows: Ayes, 29; Noes, 20.

## FIVES CLUB.

If the prosperity of the Fives Club may be judged by the number of entries for the Singles Competition, it may safely be said that this season promises to be something of a record.

There have been thirty-six entries, which far exceeds the numbers of any previous year. N. E. Cook and K. W. Mackie, the two finalists, have yet to meet, and it is an open question as to who will hold the cup this year.

The fixture list also is longer than in previous years, containing twenty matches, six of which have already been concluded. The match *versus* the Old Denstonians was scratched at the last minute owing to their being unable to raise a side.

Results up to date:

v. London School of Economics	.	.	.	Won 120-7
v. King's College, London	.	.	.	Won 97-79
v. Old Denstonians	.	.	.	Scratched.
v. Bank of England	.	.	.	Won 106-66
v. Cambridge University	.	.	.	Lost 78-111
v. University College, London	.	.	.	Won 171-110

It is hoped to start the Doubles Competition by February 1st, 1926.

## CORRESPONDENCE.

### POST-GRADUATE COURSE.

To the Editor, "St. Bartholomew's Hospital Journal."

DEAR SIR,—I have looked in vain through the last three numbers of the JOURNAL for some reference to or appreciation of the Post-Graduate Course which was held at the Hospital from September 7th to 18th.

I am sure that this omission is not due to any lack of gratitude on the part of those who attended the course, and I can only suppose that everyone thought that someone else would write about it.

I do not feel at all as well qualified as many of the others to write, as I was only able to attend the second part of the Course, and therefore can only speak of the first part from what I learnt from the others. Also I was one of the "juniors" among the class.

First let me speak of the many excellent lectures and demonstrations that were given. It would be difficult, and perhaps impolitic, to single out individual lectures for praise, but speaking generally nearly all rose to a very high level and proved of great interest to those present. The subjects, too, for the most part, were well chosen and calculated to interest the average general practitioner. Of the demonstrations one can also speak highly, and especially of those given in the special departments. Mr. Harmer is, of course, unrivalled, and there were very valuable demonstrations in the Ear and Skin Departments, where the various methods of "light" therapy proved of great interest. The subjects of "Blood Pressure," "Chest Surgery" and "Nephritis" among the lectures I heard were extremely ably dealt with and contained a mass of valuable information.

Our teachers must all have spent a great deal of time and have taken a great deal of trouble in getting up their various subjects, and I can only thank them all very heartily for what they did.

Next, I should like to say that I hope the Post-Graduate Course will be continued, if not every year, then every other year. There is no denying that, from the point of view of the Post-Graduates at any rate, this last one was a great success. I do not know if it was successful financially, but surely it could be made so. I believe that this was the first time that it has been held in September. I think those present were generally agreed that this is quite the most suitable time of the year. There are probably fewer students at the Hospital than at other times, and most of the Staff have returned from their holidays, while from the general practitioner's

point of view September is usually a fairly quiet month, and if he has a partner both have probably had their ordinary holiday.

Of course more men should attend such a course. It is always an excellent thing both to learn new and modern methods, and to have one's knowledge, which may have become a little rusty, rubbed up. An eminent physician at the Hospital told me that the men who should come to these courses do not do so, but those who, so he thought, had little need to, always attended; in other words, it is mainly the best men of their year as students who continue to seek for knowledge. I do not pretend to know what truth there is in this, or whether he was only "paying compliments." There it is for what it is worth.

In conclusion may I wish the Staff success in their efforts.

GERVAS C. WELLS-COLE.

Choristers' House,  
The Minster Yard, Lincoln;  
December 4th, 1925.

#### THE INFLUENCE OF MEDICINE IN MESOPOTAMIA.

To the Editor, 'St. Bartholomew's Hospital Journal.'

SIR,—I have read with much interest the article by Sir Thomas Carey Evans in your November number. I can corroborate all he has written about the boundless opportunities which medicine has in backward countries, just as can men on the N.W. Frontier and elsewhere. A British Minister once said, "I wish every Consul in Persia was a doctor." Many districts in this country have no medical service at all. In a tour, for instance, made just a year ago in the largest of the Caspian provinces, Mazanderan, we met only two doctors, who had received the limited training offered in this country and both living in the same town. In the whole province there is no one who can treat a serious surgical condition. It extends roughly two hundred miles from east to west and fifty from north to south, is partly mountain and virgin forest and partly swamp, intensely malarious, the tracks execrable, so that twenty miles is a good day's ride. The province of Gilan to the west has a small missionary hospital, where an American colleague does good work. To the east that of Astarabad has no hospital and no foreign doctors. Is it wonderful that opium addicts are numerous among people so cut off from ordinary medical care?

Sir Thomas was most successful with makeshifts, and they have often to be adopted in order to relieve sufferers without delay. During a fishing expedition in the mountains this summer a threshing floor served as a "table" for an amputation, and the patient's pipe as "anaesthetic." A tea-house door provided the only flat piece of wood in the district for a splint in another case, and copies of the *Times* served as padding. It takes little to turn the case of a clinical thermometer into a passable female catheter. Pure air and abundant sunlight are powerful adjuvants to surgery in desperate cases and unfavourable circumstances, among which must be mentioned flies.

Will Sir Thomas allow me to lend force to his statement about the regard felt for doctors in these countries? The Arabic words (also used in Persian) for "doctor" (*hākim*) and "governor" (*hākēm*) come from the same root, but the former has for its original meaning "a wise man." May I add that Bagdad is not one of the Shiah shrines, but that Kazimain, five miles away, is.

I am glad that Sir Thomas does not make Avicenna an Arab, as is often done. He was a Persian of the Persians, and though most of his books were written in Arabic, was, I think, never in Bagdad. I have one small work in Persian which has chapters on the pulse, on the origins of the names of diverse types of malaria, and an account of a case of artificial anus; another is a volume of short poems on medicine, also in Persian, and there are others which I have not seen. He is still quoted by Persian doctors. I often spend a day among the ruins of Rhei (Rhages), the birthplace of Mohammed Zakaria (Rhazes), who gave the first authentic clinical descriptions of measles and smallpox, sometime about the beginning of the tenth century—eighty years perhaps before the birth of Avicenna. The latter's tomb at Hamadan was described in the JOURNAL some years ago. The late Sir William Osler had all in train for an appeal for funds to restore it when the war came. I am glad to say that since then satisfactory repairs have been effected through the efforts of the local profession.

Forgive me, Mr. Editor—a rambling letter which adds nothing to the interest of your contributor's article.

Yours faithfully,

British Legation, Teheran;  
December 3rd, 1925.

A. R. NELIGAN, M.D.

#### REVIEWS.

ST. BARTHOLOMEW'S HOSPITAL REPORTS, VOL. LVIII. (London: John Murray.) Pp. 113. Price to subscribers, 15s.; to non-subscribers, £1 1s.

This volume consists chiefly of a series of articles by members of the Staff of the Hospital. In addition it contains other articles of interest to Bart.'s men. Among these are some post-mortem records of interesting cases together with their clinical histories by Sir Bernard Spilsbury, reports of cases of interest, proceedings of the Abernethian Society, those of the Paget Club, a list of new books in the Library and new specimens in the Museum.

There is an interesting article on the history of these *Reports*, describing the first volume issued in 1865, containing (by the way) over twice the number of articles that the present volume contains, amongst them being articles by Sir James Paget and Sir William Savory.

The first part of the article by Mr. L. Bathe Rawling on the vicissitudes of a patient suffering from trigeminal neuralgia is an account written by the patient himself, describing the trials and tribulations caused by his disease. More articles on these lines would be of great benefit, as they would help us to realize what patients actually do suffer.

Dr. Thursfield gives useful practical details in his article on the treatment of meningococcal meningitis, and Dr. Canti's article on the finding of tubercle bacilli in the cerebrospinal fluid of patients suffering from tuberculous meningitis is full of practical points.

Mr. C. Langton Hewer gives a good account, illustrated by diagrams, of the method he uses to produce splanchnic analgesia, and by an analysis of nineteen cases gives us some idea of the results obtained.

Mr. Wilfred Shaw contributes a careful work, which has sought to link up the relation of menstruation to ovulation, the method being based on histological findings. Evidence is adduced that ovulation occurs between the thirteenth and seventeenth days of the cycle. Good grounds are found for suggesting that the corpus luteum is responsible for the pre-menstrual changes and the formation of the decidua should pregnancy occur.

The author is to be congratulated, for his results are not only of physiological interest, but, from a pathological point of view, place the study of certain ovarian diseases on a more rational basis.

Complications of gall-stones and other cases of interest are recorded by James Maxwell, H. W. Pearson and J. E. Church.

A list of prize-winners for 1925 is given, though it is stated that they are those of 1924.

If Bart.'s men would support the Editors by subscribing to the *Reports*, and still more by contributing articles, the *Reports* would become even more valuable than they are at present.

THE HISTOLOGY OF THE MORE IMPORTANT HUMAN ENDOCRINE ORGANS AT VARIOUS AGES. By EUGENIA R. A. COOPER, M.D. (Oxford University Press, 1925.) 61 Illustrations in the Text and 1 Coloured Plate. Pp. 119. Price 12s. 6d.

The object of the research described in this volume was to determine the normal histology of certain ductless glands at different ages. That structural changes occur, particularly during the periods of growth and senescence, was known, but in the absence of precise knowledge of these changes it remained possible to confound them with the effects of disease.

The book therefore consists of a description, liberally illustrated, of the histology of the pituitary, suprarenal, thyroid, parathyroid and thymus glands at successive stages of their development and retrogression. Two criticisms may be offered: The numbers of each type of gland examined are not stated; unless they were very considerable, the *proviso* that "only those glands were chosen where it was thought that the cause of death could have little or no effect upon them" is not a guarantee that pathological changes have not been mistaken for physiological. Here, in fact, the authoress is really begging the question. In the second place, no account is taken of dimensions and weight. The first and most obvious accusation to be levelled at some of these glands in the post-mortem room is that they are of abnormal size, and accurate data in this connection would have been useful, as well as relieving the book somewhat of the vagueness of mere description. It is refreshing to read a work on the "endocrine organs" which deals with facts rather than fancies.

**TREATMENT OF GONOCOCCAL INFECTION BY DIATHERMY.** By E. P. CUMBERBATCH, M.A., B.M., B.Ch.(Cantab.), M.R.C.P., and C. A. ROBINSON, M.B., B.Ch.(Cantab.), D.M.R.E.(Cantab.). (London: William Heinemann [Medical Books] Ltd.) Pp. 145. Price 7s. 6d.

In this work the authors describe the methods which they have found most effective in the treatment of gonococcal infection by diathermy; and by a description of over a hundred cases they enable the reader to get an idea of the results obtained.

The book is essentially a practical one, and clear descriptions are given of the method of application of the electrodes, the method of adjusting the amount of current, the position of the patient, etc.

In the appendix the treatment of "metastatic" arthritis, with the primary focus (non-gonococcal) in the cervix uteri, by diathermy of the cervix is described. In the cases described good results appear to have been obtained.

**MEDICAL OPHTHALMOLOGY.** By R. FOSTER MOORE. Second Edition. (J. & A. Churchill.) Price 18s. net.

The new edition of this useful book has several advantages over its predecessor. Several valuable sections have been added on Defects of the Visual Fields due to Lesions of the Temporal Lobe, the Normal Pupillary Reactions, Intra-cranial Aneurysms and Subarachnoid Haemorrhage, Encephalitis Periaxialis, and several others. In addition excellent coloured plates and a number of black-and-white illustrations have been incorporated.

As constituted the book offers to the practitioner of medicine an excellent volume of reference in which he can find information dealing with the ocular changes, with their pathology, of practically every disease in which any such changes are present. In spite of its completeness the volume has not become unwieldy; its length of only 340 pages is a testimony to the incisiveness of the writer. In these days, when an electric ophthalmoscope is wielded with comparative success by the freshest of medical clerks, the book should be on the shelves of every practitioner of medicine who wishes to make an intelligent use of this instrument.

**NEUROLOGICAL FRAGMENTS.** By HUGHLINGS JACKSON. With Biographical Memoir by JAMES TAYLOR. (Oxford Medical Publications.)

The value of this book is threefold: it enshrines the character of Hughlings Jackson; it records the substance of much of the original work for which medicine is in his debt; it points clearly to the manner by which a clinician can, if he be also a scientist, produce scientific research of great importance.

It is impossible on reading the biographical sketches appended not to obtain a very clear impression of the character of Jackson. His clearness of purpose, honesty of thought and great independence of mind serve admirably to stimulate at the commencement of the book an interest in the scientific papers and lectures recorded in the pages that follow. His was obviously one of those characters that compel admiration and affection on the part of his house physicians and colleagues.

Although a few of his theories, such as that dealing with the cause of laryngismus stridulus, have been superseded by more recent work, the logic and accuracy of the steps leading to his conclusions in the light of contemporary physiology are so clear that the stimulus to accurate thought far outweighs any other disadvantage.

The section dealing with the mechanism of the laryngeal crises of tabes dorsalis is an extremely subtle piece of reasoning. His prose is occasionally slightly unwieldy, but careful reading will reveal that this is the result of a very conscientious endeavour to express very accurately some statement that might otherwise retain ambiguity.

He should be read by clinicians who attempt to deduce accurate facts from individual cases, whether they be neurologists or not.

**THE PATHOLOGY OF TUMOURS.** By E. H. KETTLE, M.D., B.S. Second Edition. (London: H. K. Lewis & Co. Ltd.) Demy 8vo. Pp. 284. 159 Illustrations. Price 12s. 6d.

This book consists of three parts, the first part dealing with the General Biology of Tumours, the second with their General Pathology and the third with their Special Pathology.

The book is an improvement on the first edition, especially in the sections dealing with aetiology and experimental research. There

are thirty-three new illustrations, and the photographs of the naked-eye specimens are replaced by drawings, so that their structure can be more clearly seen and understood.

In the section on the experimental study of cancer the results of Dr. Gye's recent work on fowl sarcoma are mentioned.

In the second part the vexed question of classification is dealt with, and both that of Powell White and that of Adami is described and discussed. The latter, though more cumbersome, is the more scientific and complete in that it accommodates every type of tumour.

The endotheliomata are dealt with in one section and the pros and cons of this difficult subject are discussed.

The book fulfils the object set out in the preface to provide a manual for students containing the accepted teaching on the subject and can be confidently recommended both to candidates preparing for an examination in pathology and to those who wish to make a more advanced study of the subject.

**NITROUS OXIDE.** By S. R. WILSON, M.B., C.B.(Vic.), M.Sc., F.R.C.S.E., Lecturer in Anaesthetics in the University of Manchester. (Manchester: Richard Bates.) Price 1s. 6d.

The practical value of text-books on anaesthetics is limited by the nature of the subject, which can only be learnt by continual administrations.

This little book, dealing as it does with what is perhaps the most difficult of anaesthetics, is an admirable blend of interest and usefulness. It deals with the history, preparation and mode of action of  $N_2O$  with its administration, its effects, and finally with its dosage.

The author stresses the aid of suggestion in gas anaesthesia. It is a point which is too often forgotten, and this is certainly the cause of many "bad gases," with their accompanying strain on both patient and anaesthetist! Every beginner in anaesthetics should have this book.

**IMMUNO-CHEMICAL STUDIES.** Edited by CARL H. BROWNING. (London: Constable & Co., 1925.) Pp. 239. Price 16s.

This is a collection in book form of previously published papers by five authors, two of whom are Japanese. They are concerned with the conditions governing certain antigen-antibody reactions, and may fairly be said to represent the science of immunology in its most remote and academic form. To those concerned with the chemistry and physics of immunity phenomena *in vitro* the concentration of much valuable data in a single volume should be convenient.

## RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

BROWN, W. LANGDON, M.A., M.D., F.R.C.P. Discussion on the Uses and Abuses of Endocrine Therapy. *British Medical Journal*, December 5th, 1925.

DUNDAS-GRANT, Sir JAMES, K.B.E., M.D. "Some Points in the Diagnosis and Treatment of Tuberculosis and Cancer of the Larynx." *Clinical Journal*, November 25th and December 9th, 1925.

GAUVAIN, Sir HENRY J., M.A., M.D., M.C. Discussion on Tuberculous Disease of the Spine: Conservative Treatment. *British Medical Journal*, November 21st, 1925.

GORDON-WATSON, Sir CHARLES, K.B.E., C.M.G., F.R.C.S. "Venesection and Blood Transfusion in Carbon Monoxide Poisoning." *Ibid.*, December 5th, 1925.

HAMILL, P., M.D., D.Sc., F.R.C.P. Reviser of Murrell's *What to do in Cases of Poisoning*. 13th Edition. London: H. K. Lewis & Co., Ltd., 1925.

HARVEY, FRANK, F.R.C.S.(Edin.). "Femoral Hernia: Operative Treatment by Roux's Method." *Lancet*, December 13th, 1924.

HILL, NORMAN H., M.D., M.R.C.P., and RAMSAY, R. A., M.Chir. (Cantab.), F.R.C.S. "Cystic Dilatation of the Common Bile-Duct." *British Medical Journal*, November 28th, 1925.

HOWELL, B. WHITCHURCH, F.R.C.S. "Treatment of Injuries to the Elbow in Children." *Clinical Journal*, December 9th, 1925.

JOEKES, Th., M.B.(Leiden), M.R.C.S.(Eng.). "Cultivation of the Spirillum of Rat-Bite Fever." *Lancet*, December 12th, 1925.

MORRIS, R. J., C.B.E., M.D.(Durh.), M.R.C.P. "Faecal Enterolith of the Small Intestine." *Ibid.*, October 10th, 1925.

RAMSAY, R. A., M.Ch., F.R.C.S. *See* Hill and Ramsay.

ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., D.C.L., Hon. D.Sc.(Oxon.), LL.D., P.R.C.P. "Diagnosis and Treatment of Splenic Enlargement in Children." *British Medical Journal*, December 12th, 1925.

— "Schorstein Memorial Lecture on Lymphadenoma (Hodgkin's Lymphogranuloma)." *Lancet*, December 12th, 1925.

RUSSELL, E. N., M.D. "Renal Decapsulation in Acute Nephritis with Anuria." *British Medical Journal*, November 21st, 1925.

SCOTT, SYDNEY, M.S., F.R.C.S. Discussion on Operative Treatment of Chronic Middle-ear Suppuration. *Ibid.*, December 12th, 1925.

THEOBALD, G. W., M.D., M.R.C.P., F.R.C.S. "The Value of Scopolamine-Morphine Narcosis in Labour." *Practitioner*, December, 1925.

VINES, H. W. C., M.D. Discussion on the Uses and Abuses of Endocrine Therapy. *British Medical Journal*, December 5th, 1925.

WALKER, KENNETH M., F.R.C.S., M.A., M.B., B.C. Discussion on the Uses and Abuses of Endocrine Therapy. *Ibid.*, December 5th, 1925.

WARING, Sir HOLBURT J., M.S., F.R.C.S. An Address on "Post-Graduate Medical Education in England." *Ibid.*, November 28th, 1925.

WELLS, J. PASCOE, M.A., M.B.(Cantab.), M.R.C.S. "Fatal Syncope due to Injudicious Eating." *Clinical Journal*, November 25th, 1925.

YOUNG, F. H., M.B.(Cantab.), M.R.C.P. "A Case of Calcification of the Pleura of an Unusual Type." *Lancet*, December 12th, 1925.

### EXAMINATIONS, ETC.

#### UNIVERSITY OF OXFORD.

The following degrees have been conferred:  
B.M.—N. Chilton, F. J. Bach.

#### UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:  
B.M., B.Chir.—J. H. T. Davies.

#### UNIVERSITY OF LONDON.

*Third (M.B., B.S.) Examination for Medical Degrees.*  
Pass.—R. G. Anderson, A. B. Cowley, R. N. Curnow, G. S. Hale, D. G. Martin, M. D. Rawkins.  
*Supplementary Pass List, Group I.*—R. T. Bannister, F. H. K. Green, C. E. Pearson, H. Treissman.  
*Group II.*—F. A. Bevan, E. J. Blackaby, T. D. Deighton, D. B. Fraser.

#### ROYAL COLLEGE OF PHYSICIANS.

The following was omitted from the list of Members in the December number:  
J. Maxwell.

#### ROYAL COLLEGE OF SURGEONS.

The Diploma of Fellow has been conferred on the following:  
G. H. Caiger, N. L. Edwards, N. A. Jory, I. Morris, R. T. Payne, G. S. Sinnatamby, T. Meyrick Thomas, B. M. Tracey, J. A. Panton, C. P. Wilson.

The following have passed the examination, but not having attained the requisite age are not yet entitled to receive the Diploma:  
H. Burt-White, A. C. Maconie.

### CHANGES OF ADDRESS.

AUSTEN, A. E., St. Denys, Hadleigh Road, Leigh-on-Sea.

BROOKE, C. O. S. B., Hampstead General and N.W. Hospital, Haverstock Hill, N.W.

BROWSE, G., Scotleigh, Chudleigh, S. Devon.

DEARDEN, J. R. B., "West Royd," Hebden Bridge, Yorks.

FIDDIAN, E. A., Hempstead House, 2, Seaside Road, Eastbourne. (Corrected notice.)

GALLOP, E., 13, Belsize Park, Hampstead, N.W. 3. (Tel. Hampstead 998.)

GILLON, G. GORE, 14, Spencer Road, Ryde, Isle of Wight. (Tel. Ryde 276.)

GRIPPER, W., Park House, Willingdon, Sussex.

HAMILTON, W. G., Lt.-Col. I.M.S., East India United Service Club, 16, St. James's Square, S.W. 1.

MELLER, R. W., Mil Lane House, Felixstowe.

MORRIS, H., 78, Southampton Street, Reading.

SELBY, PRIDEAUX G., Beautil, near Teynham, Kent.

SHAW, H. C. C., Hospital for the Insane, Goodna, Queensland, Australia.

TOMS, H. W., c/o British Embassy, Bangkok, Siam.

WHITE, C. PERCIVAL, 7, Albany Villas, Hove.

### APPOINTMENTS.

BROOK, C. W., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer, Southwark Hospital, E. Dulwich Grove, S.E.

BROOKE, C. O. S. B., M.B., B.S., appointed House Surgeon, Hampstead General and N.W. Hospital, Haverstock Hill.

HISCOCKS, H. F., M.R.C.S., L.R.C.P., appointed House Physician, Royal Chest Hospital, City Road, E.C.

OULTON, E. V., M.B., B.C., D.O.M.S., appointed Ophthalmic Surgeon, Brighton Infirmary; Hon. Ophthalmic Surgeon, Haywards Heath Hospital; and Hon. Ophthalmic Surgeon, Hove Hospital.

POOLE, F. D. S., M.B., B.S. Lond., appointed House Surgeon, Royal Hants County Hospital, Winchester.

### BIRTHS.

LOVEDAY.—On November 20th, the wife of Dr. G. E. Loveday, Spring Lodge, Fallowfield, Manchester, of a son.

STOCKER.—On December 17th, at Harpenden, to Madeleine (née Storrs Fox), wife of Maj. C. J. Stocker, I.M.S.—a daughter.

### MARRIAGES.

TUNBRIDGE : RODDY.—On December 15th, at Holy Trinity Church, Leamington Spa, by the Right Rev. Charles Leslie Carr, D.D., Lord Bishop of Coventry, assisted by the Rev. C. E. Morton, vicar, and the Rev. H. C. Cockerell, William Stephen Tunbridge, M.A., M.B., B.Ch.(Oxon.), third son of Lt.-Col. W. S. Tunbridge, of Castel Froma, Leamington, to Mildred Emma Leathers, the younger daughter of Col. Roddy, C.B., and Mrs. Roddy, of Bareilly, Leamington.

WIGHT : TEMPLETON.—On December 8th, at All Souls', Langham Place, by the Rev. Arthur Buxton, Cecil Harold, second son of the late Rev. Alfred Wight, M.A., and Mrs. Wight, of Idesleigh, Knyveton Road, Bournemouth, to Dorothy Kerr, only daughter of David Templeton, of Carrick Lodge, St. Winifred's Road, Bournemouth.

### DEATHS.

NORBURY.—On December 10th, 1925, at "St. Margaret's," Eltham, Sir Henry Frederick Norbury, K.C.B., M.D., F.R.C.S., Hon. Surgeon to the King, Inspector-General of Hospitals and Fleets, Royal Navy (retired), aged 86.

PALGRAVE.—On December 13th, 1925, Edward Francis Palgrave, M.R.C.S., L.R.C.P., 218, Cheniston Gardens, Kensington, aged 49.

### NOTICE.

All Communications, Articles, Letters, Notices, or books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, ST. BARTHOLOMEW'S HOSPITAL, SMITHFIELD, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, THE JOURNAL OFFICE, ST. BARTHOLOMEW'S HOSPITAL, E.C. Telephone: CITY 510.